Patient Education In Primary Care

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2001: WHAT WERE JCAHO SURVEYORS LOOKING FOR?

A sampling of interviews with patient education coordinators and committee chairs in six VISNs reveals some patterns in the JCAHO surveys they all experienced this year as well as some unique innovations they have implemented at their facilities to help them meet the patient and family education standards.

Patient Education Integration

There were no focused interviews for patient education coordinators or committees this year. Most coordinators had no contact with surveyors; two of the coordinators interviewed for this article were each asked only a single question about patient education as part of a group session with other committee chairs. Some of the coordinators found this disappointing after the amount of work they had done preparing for the survey visit, but most agreed that the survey itself was less stressful for them because of the new JCAHO approach. Kathleen Theisen, PHE Committee chair at VAMC St. Cloud, MN noted, "This was the most benign survey I've seen in thirty years." Rosemary Gill, PHE Coordinator at the VA Palo Alto Health Care System, CA, commented, "We had to let the documentation of our work speak for us, which is as it should be." None of the six sites received any deficiencies or recommendations regarding patient education, and several received compliments from surveyors about specific aspects of local patient education programs. Theisen said, "The lack of recommendations for patient education is a tribute to our staff. We take it as a positive sign that we're doing things right."

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WELCOME TO OUR RESOURCE FOR PATIENT EDUCATION AND PRIMARY CARE![1]

WHAT IS IT?

This newsletter provides a mechanism to help meet the challenges of incorporating effective patient education into primary care.

WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decision makers.

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Patient Education Binders

Each site prepared binders for the surveyors that displayed prominent aspects of their programs. Most sites organized their binder tabs according to the JCAHO standards, including examples of programs, activities, and patient materials for each standard. At VA Palo Alto, Rosemary Gill prepared four binders for the surveyors:

1) minutes from PHE committee meetings for the previous twelve months;
2) performance improvement activities related to patient education in a plan/do/check/act format with synopses of each effort and supportive documentation;
3) listings of patient education classes; and
4) tabbed information on each of the patient education standards demonstrating how the medical center was addressing each standard, along with samples of patient handouts.

Gill added a new feature to this binder. She included actual progress notes from medical records (minus patient identification information) in each tab to demonstrate how the notes addressed the standard. She said, "Members of the PHE committee were very helpful in sharing their notes as were other clinicians in the medical center who are involved in patient education. And the surveyors were impressed by the binders."

At St. Cloud, Kathleen Theisen said preparing the binder was very helpful to the PHE Committee, not just to the JCAHO surveyors. "It was a good tool to show us where we had strength and where we needed to focus attention."

Judy Nassmacher, PHE Coordinator at VAMC Dayton, was involved in preparing two sets of binders for JCAHO surveyors. Since VISN 10 was seeking accreditation as a VISN, the network patient education committee, of which Judy is a member, prepared a binder displaying how the VISN was addressing patient and family education standards. Then each facility prepared its own binder, making sure that content was consistent and flowed from the VISN notebook. Nassmacher reported that surveyors particularly liked two components of the VISN patient education program—the quarterly patient education newsletter, and the four best practice groups (smoking cessation, diabetes, stroke education, and patient orientation)—that have been established to help facilities in the network reach and maintain specified patient education standards.

Less Emphasis on Program Structure

All of the interviewees remarked that the surveyors spent little time reviewing the organizational structure of the patient education program. As Sonja Wagener, PHE Coordinator at VAMC Miami, FL commented, "They know we've got that in order, so they didn't need to review it in detail."

More Emphasis on Documentation

The interviewees agreed that the survey emphasis for patient education was on documentation. Leslie Tarvin, PHE Committee chair at VAMC Roseburg, OR, said that they had developed a number of assessment and education templates for the electronic medical records at her facility, and that helped them meet the documentation standards. They're also adding assessment of barriers to learning to the clinical reminders which should help clinicians address that requirement. During the JCAHO survey at Roseburg, surveyors spent more time looking at current records on the units than at closed records from the file room to see how patient education documentation was being done.

> "It's been a difficult task, but we've tried to set it up so that the computerized documentation system itself walks staff through a good educational process. We want it to guide people, to help them provide good patient education, and to make their jobs easier."

Rene Haas, PHE Coordinator at the VA Long Beach Health Care System, CA, said that her facility had worked very hard in recent years on the computerized patient record system. Now 80% of the documentation there is electronic. They have developed a health summary under the reports tab in CPRS titled Patient Education Index. It includes patient education clinical reminders, health education topics, progress notes of patient education classes, and other progress notes that routinely contain patient education such as notes on food/drug interactions and diabetic foot exams. She noted that she has worked with clinical staff in each area on the health education topics so that they could tailor the topics they need to address with the patient. Haas commented that the 18 months of work they did to help staff and patients address the pain management and pain education standards paid off in the documentation evident in the JCAHO survey.

At Miami, Sonja Wagener said one of the challenges was to design an electronic record documentation system that would show the flow of patient education. "It's been a difficult task," she said, "but we've tried to set it up so that the computerized documentation system itself walks staff through a good educational process. We want it to guide people, to help them provide good patient education, and to make their jobs easier. For example, the health summary pulls all the notes together from the various disciplines. The system is still somewhat awkward, but we're hoping that future software refinements will make it smoother. Patient education at our medical center has been designated as a pilot for parent-child documentation, so we're looking forward to the enhancements that we'll be able to test out."

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Preparing for the JCAHO Survey

At Dayton, the Quality Manager assigns key staff to the various chapters of the JCAHO manual. These staff members form the JCAHO core group, which begins work a year in advance of the survey. As the PHE Coordinator, Judy Nassmacher was designated as the lead for the patient/family education chapter. She worked with the PHE Committee to assess what had been accomplished and what still needed to be done to get ready for the JCAHO survey. After three months of assessment, each lead person was required to prepare a written report for top management outlining findings and recommendations. Core group members also met with top management to discuss the report, to explore the resources available and needed to implement the recommendations, and to coordinate efforts among the various staff. Monthly meetings of the core group were held to monitor progress on achieving the recommendations prior to the JCAHO survey.

In addition, each patient care line at VAMC Dayton is required to conduct a quarterly audit on patient education documentation and submit a report to the PHE Committee, including action plans as needed to address deficiencies. All patient care lines are represented on the PHE Committee.

VAMC St. Cloud hosted a JCAHO Fair for staff. Each chapter was represented at a table. The PHE Committee organized activities and games to familiarize staff with the patient/family education standards.

At Miami, Sonja Wagener conducted a number of inservice sessions to prepare staff to document patient education using the computerized record system. "The best part of it, even with the pressure of the new technical requirements for staff and the upcoming JCAHO survey, was that it gave me an open door to teach staff a good process to provide and document patient education."

Advice for the Future

Leslie Tarvin recommends addressing patient safety issues and patient safety education in a substantive way, including surveying patients about safety issues at home. Rene Haas says they'll be putting more emphasis at VAMC Long Beach on assessing patient satisfaction with the patient education received, especially medication instructions. Rosemary Gill encourages facilities to continue to address pain education and to address herbal and alternative medicine approaches in their patient education programming. And Sonja Wagener advises staff to read the standards carefully and use the VHA network of PHE contact persons to help them with their local efforts. "It's an incredible resource, and we should take more advantage of it than we do," she said.

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Patient Education and the Internet

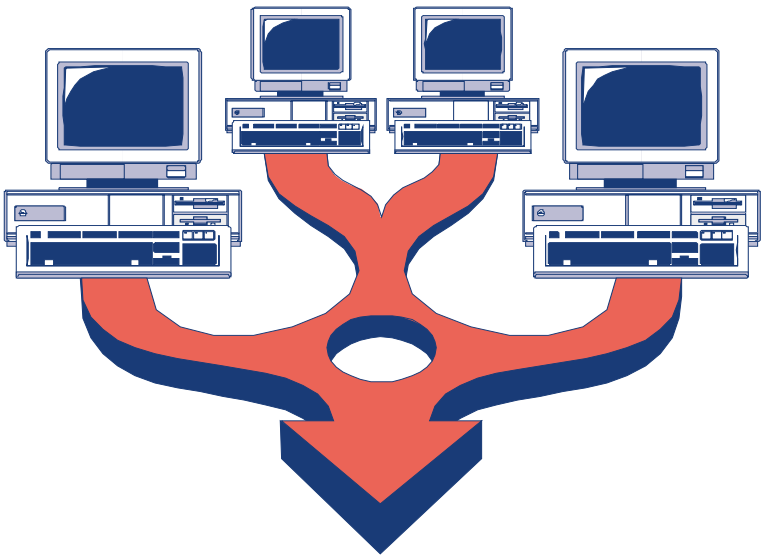
Pamela A. Hebert, DrPH

(This article is adapted from a presentation made by Dr. Hebert at the VHA Ambulatory Care Conference in San Diego, CA in August, 2001)

Over 163 million Americans have access to the internet. Recent survey findings published in Psychology Today indicate that 36% of the respondents believe the internet is a necessity. We now have the capability of bombarding people with information, but the challenge is: how can we use the internet as an effective tool for patient education?

It is estimated that 40.9 million people use the internet for health purposes, including:

- finding health information
- asking experts for advice
- requesting second opinions
- seeking social support for health conditions
- scheduling appointments for health care



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- changing health behaviors.

Unfortunately, accomplishing these tasks on the internet can be challenging.

- Health information may be inaccurate or misleading.
- It may be hard to find and hard to read and understand.
- Advertisements are often located in inappropriate places.
- Health information may not be applicable to all users.
- Key information may be missing.
- Users may lack the skills needed to locate pertinent resources on the web.

We know from previous research that information alone is not sufficient to help patients make long-term changes in their health behavior. For example, there is an enormous amount of information on the internet about hormone replacement therapy, but it can be frustrating and confusing to many women to interpret whether it would be a good choice for them. Without someone to discuss their particular situation and their specific concerns, many women are left overwhelmed and confused by the information.

Even though the United States spends more on health as a percentage of its gross national product than any other nation, we rank only 72nd in health efficiency ratings, indicating that the level of health in our country is not what it should be given the dollars we spend. Obesity is a classic example. 55% of American adults are overweight, which predisposes them to various illnesses and chronic conditions. Yet few patients receive effective treatment and education for weight management. In many health insurance programs primary care clinicians are not reimbursed for preventive or behavioral care for weight control, yet we know that weight control is a complex behavioral problem. Many behaviors must be addressed in the change process—reducing dietary fat, portion control, increasing fruit and vegetable consumption, and increasing physical activity—if patients are to be successful. Hypertension is another good example. Forty-two million Americans suffer from hypertension yet only 10 million are successfully treated. 72% of patients do not adhere to treatment regimens or have let treatment lapse. From the clinician's view, it may be difficult to find time to counsel patients about hypertension treatment. Some clinicians may fear treating hypertension too aggressively. From the patient's view, it can be difficult to make the lifestyle changes required of the regimen, especially since the changes must be sustained for the rest of the patient's life.

We know that at least 60% of all primary care visits have a psychosocial component, but there is still great reluctance on the part of many clinicians to attend to these concerns, given the shortened length of medical care visits and the perceived complexity of dealing with these issues. Yet these concerns can have a large impact on the patient's readiness and skill to change behavior. At the same time, more people are using alternative healers and herbal supplements and treatments. Patients have a desire to be treated as an ecosystem, and research supports the need to link body, mind, and spirit. An integrated approach to helping patients adopt healthy behaviors may be more effective, regardless of whether the intervention is provided to individuals, to small groups, or via the internet.

EFFECTIVE INTERNET PATIENT EDUCATION STRATEGIES INCLUDE:

- easy to use formats
- easy to read text
- creative approaches to engage attention and make messages memorable
- graphics that can compete with commercial products
- interventions that are linked to the process of health care
- interventions that are linked to caring human beings.

Patients are at different stages in their readiness to change health behaviors. They also vary greatly in terms of which behaviors they want to change. Recent studies that have used the internet as an intervention tool for behavior change have found that the same approaches that make face-to-face education effective are the ones that make internet education effective. These include:

- targeting specific behaviors that influence health outcomes
- staging interventions to match the patient's readiness level
- tailoring interventions to the individual person's needs and capabilities
- making messages memorable and including memory boosters to help patients manage behaviors at home.

Effective internet patient education strategies include:

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- easy to read text
- creative approaches to engage attention and make messages memorable
- graphics that can compete with commercial products
- interventions that are linked to the process of health care
- interventions that are linked to caring human beings.

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HOW DO WE KNOW PATIENT EDUCATION WORKS?

EFFECTS OF PHYSICAL ACTIVITY COUNSELING IN PRIMARY CARE

Eleven primary care facilities affiliated with three clinical research centers participated in this randomized controlled trial comparing the effects of two physical activity counseling interventions with current recommended care and with each other. Participants included 395 female and 479

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male inactive primary care patients aged 35 to 75 without clinical cardiovascular disease.

Participants were randomly assigned to one of three groups: advice, which included physician advice and written educational materials (recommended care); assistance, which included all the advice components plus interactive mail and behavioral counseling at physician visits; or counseling, which included the advice and assistance components plus regular telephone counseling and behavioral classes.

Cardio-respiratory fitness measured by maximal oxygen uptake, and self-reported total physical activity measured by a 7-day Physical Activity Recall were compared among the three groups and analyzed separately for men and women at 24 months. For women, VO(2)max was significantly higher in the assistance group than in the advice group and in the counseling group than in the advice group. There was no difference between the counseling and assistance groups, and no significant differences in reported total physical activity. For men, there were no significant between-group differences in cardio-respiratory fitness or total physical activity.

The authors concluded that the assistance and counseling interventions were equally effective in women in improving cardio-respiratory fitness over 2 years compared with recommended care. In men, neither of the two interventions was more effective than recommended care.

The Writing Group for the Activity Counseling Trial Research Group. (2001) Effects of physical activity counseling in primary care: the Activity Counseling Trial: a randomized controlled trial. JAMA 286(6):717-9.

Relapse Prevention of Depression in Primary Care

The authors hypothesized that a relapse prevention intervention would improve adherence to antidepressant medication and improve depression outcomes in high-risk patients since few primary care patients with recurrent or chronic depression receive continuation and maintenance-phase treatment.

Three hundred eighty-six patients with recurrent major depression or dysthymia who had largely recovered after 8 weeks of antidepressant treatment by their primary care physicians were randomized to a relapse prevention program or to usual primary care. Patients in the intervention group received 2 primary care visits with a depression specialist and 3 telephone visits over a 1-year period aimed at enhancing adherence to antidepressant medication, recognition of prodromal symptoms, monitoring of symptoms, and development of a written relapse prevention plan. Follow-up assessments were completed at 3, 6, 9, and 12 months by a telephone survey team blinded to randomization status.

Patients in the intervention group had significantly greater adherence to adequate dosage of antidepressant medication for 90 days or more within the first and second 6-month periods, and were significantly more likely to refill medication prescriptions during the 12-month follow-up compared with patients in the usual care group. Episodes of relapse-recurrence over the 12-month follow-up period were similar for patients in both groups, but intervention patients had significantly fewer depressive symptoms during that period.

Katon W, Rutter C, Ludman EJ, Von Korff M, Lin E, Simon G, Bush T, Walker E, Unutzer J. (2001) A randomized trial of relapse prevention of depression in primary care. Archives of General Psychiatry 58(3):241-7

Alcohol Screening and Health Education with Older Primary Care Patients

This study evaluated the feasibility of a combined alcohol-screening and health education system for elderly patients. The Computerized Alcohol-Related Problems Survey (CARPS) was evaluated in primary care practices among 106 current drinkers, aged 60 years and older. The CARPS contains 1) a self-administered screening survey; 2) software to scan or hand-enter responses; 3) software to process data and electronically generate reports of drinking risks; 4) health education; and 5) a database useful for clinical and quality improvement purposes.

Nearly all study participants were able to complete the CARPS while waiting for a scheduled appointment with their physicians. 44% of patients were found to be hazardous and 9% were harmful drinkers. About 20% of men and 26% of women were binge drinkers. Most (85%) of patients agreed that alcohol is an important topic, 67% reported learning new information, 78% had never discussed drinking

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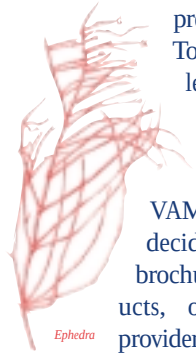
with a physician, and 31% intended to do so. After reviewing CARPS data, physicians concluded that alcohol use in the elderly is an important quality improvement topic.

Nguyen K, Fink A, Beck JC, Higa J. (2001) Feasibility of using an alcohol-screening and health education system with older primary care patients. Journal of the American Board of Family Practice 14(1):7-1

Patient Education/Primary Care Program Notes

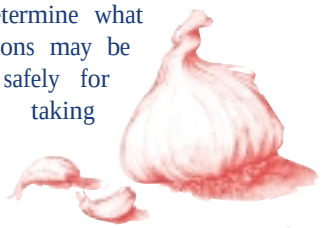
What Patients Need to Know about Herbal Supplements

Clinicians may neglect to ask patients about herbal supplements they're taking, and patients may report symptoms that actually represent side effects of ingesting herbal products while taking prescription medications. To alleviate these problems, the Complementary/Alternative Medicine Committee at VAMC Loma Linda, CA decided to produce two brochures on herbal products, one for health care providers, and one for patients. Norv Walker, chair of the committee, says the brochures helped patients "open up" to discussing herbal products with their clinicians. This has resulted in better communication between patients and providers, and better health care because more information is now available to both patients and providers. According to Maral Anjargolian, the clinical pharmacist who researched the topic and drafted the brochures, the brochure for providers served as a credible tool to help them determine what prescriptions may be written safely for patients taking herbal products. Surgical staff have also found it useful in assessing what herbal products patients may be taking and what must be changed or eliminated prior to surgery.

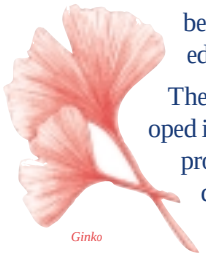


Ephedra

Echinacea

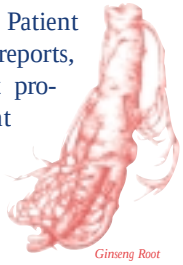


Garlic



Ginko

The brochures were developed in 1999. Copies of the provider brochure were distributed to physicians. Copies of the patient brochure were placed throughout the facility in display racks located in inpatient areas, clinics, and in the health resource center. As Sandee Cegielski, Patient Education Specialist, reports, "When they were first produced, the patient brochures would disappear from the racks within hours. We got lots of requests from patients for the brochure."



Ginseng Root

The facility has had over 200 requests from VHA staff at other facilities for the brochures. Electronic copies were distributed to all chiefs of nursing services earlier this year. In July, the two brochures were updated and combined into one booklet as a VISN 22 project.

Chamomile

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Performance Improvement Training

Every quarter, Patient Education in Primary Care will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit, choose one of the following two options:

Read the entire October 2001 newsletter and provide brief answers to the questions below. Turn these in to your supervisor along with a copy of the newsletter

OR

Organize a one-hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter and discuss the questions below. Turn in a master list of participants along with a copy of the newsletter.

Questions:

1. In terms of the JCAHO patient/family education standards, where are your facility's strengths? Its weaknesses? What would you recommend to enhance the strengths and overcome the weaknesses?
2. What suggestions would you have for helping staff at your facility better prepare for JCAHO or other external accreditation surveys?
3. How could you use the internet to enhance the patient education services offered to patients at your facility?
4. How could you effectively use brochures on herbal supplements for clinicians and patients at your facility?

DO YOU HAVE ANY SUCCESSFUL PATIENT EDUCATION STRATEGIES THAT YOU WOULD LIKE TO SHARE WITH US?

Contact any of the following with your input:

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TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES.

PATIENT HEALTH EDUCATION IN PRIMARY CARE TASK FORCE:

This newsletter is transmitted electronically to VHA staff. To add colleagues to the distribution list, contact your local patient education coordinator or committee chairperson.

Office of Primary and Ambulatory Care